Carolina ACCESS Enrollment Form

(To be used only for children ages 0-5 transitioned from Health Choice to Medicaid.)

Please note: ALL information is required to process enrollment form.

PROVIDER INFORMATION

Practice Name as Enrolled in Carolina ACCESS: _____

Carolina ACCESS Practice Medicaid ID#: _____

Telephone # of Practice: _____

PATIENT CONTACT INFORMATION

Date: _____ **Parent/Guardian:** _____

Address of Patient: _____

_____

County: _____ **Telephone # of Patient:** _____

List each Recipient being enrolled in Carolina ACCESS:

Recipient Name (as it appears on Medicaid card)	Date of Birth	Recipient ID (MID)	Social Security # (SSN)

Signature of parent/guardian (REQUIRED):
By signing below, I certify that I have received an explanation of Carolina ACCESS and my freedom to choose any participating PCP.

_____ **Date**: _____

Signature of Enroller (REQUIRED):
By signing below, I certify that I have explained Carolina ACCESS, including the freedom to choose a PCP other than myself.

_____ **Date**: _____

Mail or fax the completed Enrollment Form to:

Laurie Moore
Managed Care, 16 OBAP
DHHS/Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Phone: (919) 647-8170

Fax: (919) 715-0844
(919) 715-5235

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